Addressing Structural Barriers to HIV Care among Triply Diagnosed Adults: Project Bridge Oakland

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People who are “triply diagnosed” with HIV, mental health issues, and substance-related disorders face tremendous barriers connecting to and remaining in HIV care. Authors of this article implemented Project Bridge Oakland (PBO), an intervention based on harm reduction and trauma-informed care, to help maintain continuity of care for triply diagnosed adults through cycles of criminal justice involvement. From August 2011 to December 2014, a clinical social worker and an HIV physician provided intensive case management for 19 clients living in Oakland, California. By working with clients across a multitude of community, clinic, and correctional spaces while maintaining a low threshold for services, the social worker was able to engage a severely marginalized population in HIV care. This article details the PBO strategies for assisting with a wide range of services needed for community stabilization, navigating criminal justice involvement, and establishing a therapeutic relationship through mundane practices such as eating and waiting for appointments. This article illustrates how programs aimed at stabilizing triply diagnosed clients in the community and connecting them to HIV care require coordination among providers, outreach to engage clients, ample time to work with them, and flexibility to account for the complexities of their day-to-day lives and experiences.

KEY WORDS: *case management; HIV; homelessness; incarceration; mental health*

In this article, we describe an approach that combines principles of the peer navigation model (engaging clients in the community), the assertive community treatment (ACT) model (partnering a social worker and a physician to provide wraparound services), and traditional case management (counseling) to engage triply diagnosed adults in HIV care. This intensive case management program, called Project Bridge Oakland (PBO), was created specifically to improve engagement in and continuity of HIV care among triply diagnosed people with criminal justice involvement. In designing this program, our team focused on meeting the needs of an impoverished, unstably housed population that was largely disconnected from services and held a deep distrust of institutional authorities. As such, PBO provided continuous case management across community, clinic, and correctional settings and was based on the principles of harm reduction, trauma-informed care, and flexible service provision. In this article, we examine the

innovative strategies used in PBO to better understand how to address the unique and intertwined needs of triply diagnosed adults with criminal justice involvement when engaging and retaining them in HIV care.

Among the approximately 1.2 million people living with HIV in the United States, only 40 percent are engaged in HIV care and only 30 percent have achieved recommended levels of viral suppression ([AIDS.gov](https://aids.gov), 2015). Engagement in HIV care is even less common among people who also have mental health and substance use issues (often termed “triply diagnosed”) ([Eisenberg & Blank, 2014](#)). Barriers to engagement in care and viral suppression for this population include poverty, stigma, food insecurity, and homelessness ([Christopoulos et al., 2013](#)). These factors also pose barriers to engagement with mental health services or substance use treatment, creating a vicious cycle in which people with high needs are disconnected from access to any form of care ([Buckley & Bigelow, 1992](#)). Given

the complexities that triply diagnosed adults deal with, it is unlikely that there will be a “one size fits all” best practice for their connection and retention in HIV care. Rather, multiple evidence-based approaches should be available so that people can receive services that meet their individual needs.

Triplically diagnosed adults are frequently subjected to incarceration. Although data on the numbers of incarcerated triply diagnosed people does not exist, it is known that an estimated one in seven HIV-positive adults is incarcerated in jail or prison each year (Iroh, Mayo, & Nijhawan, 2015) and that incarcerated populations are disproportionately affected by mental health issues and histories of substance use (James & Glaze, 2006; Karberg & James, 2005; Mumola & Karberg, 2006). Although incarceration for a sustained period can help stabilize HIV care (Beckwith, Zaller, Fu, Montague, & Rich, 2010; Wakeman & Rich, 2010), short-term incarceration often has the opposite effect, disrupting care that was established in the community, while not providing enough time for correctional HIV care to be established (Milloy et al., 2011). Furthermore, the difficulties of accessing HIV care and medications after release from correctional custody can swiftly degrade a person’s health when returning to the community (Baillargeon et al., 2009; Iroh et al., 2015).

A variety of case management and advocacy approaches have been developed to link and retain triply diagnosed adults in HIV treatment. For example, many HIV clinics offer on-site support services such as counseling, and recent research indicates promising results for providing brief strengths-based case management interventions to connect newly diagnosed HIV patients to medical services (Craw et al., 2008). Likewise, efforts to integrate substance use and HIV treatment have been found to decrease alcohol use, drug use, anxiety, and depression, highlighting the advantages of including social workers as part of a holistic treatment team (Proeschold-Bell et al., 2016). However, clinic-based programs may have difficulty engaging clients who are afraid, unwilling, or otherwise unable to come to a specific location. Indeed, studies have shown that triply diagnosed adults are less likely to attend scheduled health care appointments, which suggests that simply adding services to these appointments might have limited utility (Johnson, Polansky, Matosky, & Teti, 2010; Walkup et al., 2008).

Programs that extend out of the clinic and into the community have been found to be effective in engaging and re-engaging HIV-positive adults who are out of care (Nunn et al., 2010). The patient navigation model, for example, teams “peer navigators” (HIV-positive people from similar socioeconomic backgrounds as the patients) with HIV-positive adults to facilitate linkage to and retention in HIV care and other community resources (Koester et al., 2014). As noted by Wheeler (2011), partnering peer navigators and social workers in their work with clients could be an effective means of maximizing the benefits of this model. In a similar vein, the ACT model uses a team-based approach (combining the services of a psychiatrist, doctor, and social worker) to provide wraparound services to increase community stabilization and decrease the need for institutionalization. Although not developed specifically around issues of HIV care, ACT has been found to be effective in working with adults with severe mental illness (Phillips et al., 2001).

METHOD

The Project Bridge intervention was first developed and piloted in Rhode Island to link and retain HIV-positive adults discharged from state prison to HIV care in the community (Rich et al., 2001). PBO was the intervention arm of a larger study in which an outreach worker recruited people who use drugs to receive a rapid oral HIV test and participate in a quantitative interview ($N = 2,424$) (Lorvick, Comfort, Krebs, & Kral, 2015). A total of 69 people tested HIV positive in the source study and were screened to determine whether they were currently engaged in HIV care. Participants who were not in HIV care were offered participation in PBO. We operationalized “not currently in HIV care” as having not seen a physician for HIV care in the past three months, not having a scheduled appointment with an HIV provider, and not currently taking HIV medications. Relatively few people met the PBO eligibility criteria of being HIV positive and not engaged in care. A total of 19 participants were enrolled in the intervention between November 2011 and August 2013, half of whom were recruited through the source study, with the other half being referred by the HIV discharge coordinator of the local county jail.

Clients enrolled in PBO received intensive case management provided by a master’s level clinical

social worker and medical care provided by an HIV physician. Services were provided from the time of enrollment through December 2014. The social worker had over 10 years of experience working with people who had experienced trauma and incarceration. Similarly, the HIV physician had extensive experience providing HIV care at public clinics in underserved neighborhoods of the city. The social worker and physician conducted weekly case conferences to evaluate patient progress and strategize about how to remove barriers to engagement in care and medication adherence. A portion of this time was dedicated to administrative tasks related to basic needs like housing and federal Supplemental Security Income (SSI) applications. For patients dealing with multiple life stressors, it was critical to have a plan of care coordinated by and centralized within the PBO treatment team to assist them in navigating various bureaucratic systems. In addition to case conferences, the social worker had weekly clinical supervision with a licensed clinical social worker who specialized in severe psychiatric issues and incarceration.

All PBO clients provided informed consent to participate in the research study and were paid \$20 every three months to complete a viral load blood draw and short quantitative interview. No monetary compensation was provided for the case management services. In accordance with the standard of care, the social worker kept clinical notes from each client interaction. All names used in this article are pseudonyms.

RESULTS

PBO Client Characteristics

Although PBO did not work in what is considered a “traditional” therapeutic setting, the social worker drew on psychodynamic therapeutic principles to understand four key concepts: (1) What is the client’s world like and how does he or she experience it? (2) How do the client’s past experiences influence his or her present ones? (3) What is the client’s overall functioning? (4) What coping mechanisms does the client rely on and how do these help or harm him or her? (Thompson & Cotlove, 2005).

Of the 19 PBO clients, four were cis-women, two were trans-women, and 13 were cis-men. Sixteen identified as African American, one as white, one as Latino, and one as Native American and African American. At the time of enrollment, one client was 26 years old, six were between the ages

of 31 and 40, 11 were between the ages of 41 and 64, and one was 65 years old. Four PBO clients were newly diagnosed with HIV at the time of enrollment. Thirteen clients reported smoking crack cocaine only and six clients smoked crack cocaine and injected drugs. All clients were homeless when enrolled—13 were living on the street, two were staying in a homeless shelter, and four were staying with relatives or friends.

All PBO clients also had histories of incarceration and mental illness. Self-reported diagnoses included schizoaffective disorder, schizophrenia, major depressive disorder, and posttraumatic stress disorder. In addition, all clients presented with complex trauma histories including experiences such as childhood neglect and abuse, child welfare system involvement and foster care placement, juvenile detention, homelessness during adolescence, sexual and physical assaults during adulthood, and the deprivation associated with chronic poverty. Notably, eight of the 19 clients had suffered gunshot wounds during their lifetime, and all of the cis- and trans-women had experienced childhood sexual abuse.

While enrolled in the intervention, PBO clients cycled through periods of community instability, incarceration, violence, and medical crises. Five clients were hospitalized for pneumonia, all during postincarceration periods when they slept on the street and were vulnerable to HIV-related opportunistic infections. Four clients were put on an involuntary psychiatric hold, and two suffered psychotic episodes. Two overdosed and were administered the opioid antagonist naloxone by medical professionals. Four clients were hospitalized for violent assaults; one suffered a gunshot wound, two suffered skull fractures, and one was stabbed.

PBO Services and Strategies for Engagement

The central tenets of PBO were harm reduction (Harm Reduction Coalition, 2015), trauma-informed care (understanding the signs, symptoms, and impact of trauma) (Clark, Classen, Fourt, & Shetty, 2015), and flexible service provision. During the course of PBO, the social worker connected every client to HIV care—and every client “fell out of care” at some point, based on clinical factors such as missed appointments, poor medication adherence, and lack of contact with the providers. With PBO case management services, 15 clients managed to reconnect to care and

four remained consistently out of care. As elaborated in the following sections, PBO strategies for engaging, maintaining, and reconnecting clients were wide-ranging and therapeutically informed.

Establishing the Therapeutic Frame: Creating a “Holding Environment”. In a traditional therapeutic setting, the holding environment refers to the psychological space created between the clinician and client where the clinician “holds” the client’s most unmanageable thoughts and feelings (Ogden, 2004; Winnicott, 1960). In community mental health settings, the concept of the holding environment can include the physical space as well as material items provided (Brandell & Ringel, 2004). Within its physical office space, PBO strove to create a stable holding environment where clients could feel physically and psychologically safe even when other aspects of their lives were heavily disrupted. The PBO office was located adjacent to multiple forms of public transportation and walking distance from numerous residential hotels. At the office, the social worker distributed free bus passes, snacks, condoms, toiletries, and donated clothes, and gave clients access to a bathroom, hot beverages, and a phone. In addition to meeting with the social worker, clients used the space to charge their cell phones, heat food in the microwave, and pick up their mail. Clients also stored their belongings at the PBO office during or after periods of incarceration—items that would have otherwise been discarded by a homeless shelter or left on the street. This practice served two clinical purposes: It provided a physical holding environment that contributed to the client’s sense of emotional containment (Casement, 1991) and encouraged clients to reconnect with PBO after being released from jail.

Getting out of the Office: Making Services Accessible. The social worker engaged clients in multiple settings. Two-thirds of all PBO contacts happened outside of the office, in venues including but not limited to jails, hospitals, health clinics, homeless shelters, homeless encampments, courts, the Department of Motor Vehicles, the parole office, food banks, and other places not traditionally thought of as clinical spaces but frequented by clients, such as a check cashing store and a Dollar Store. Likewise, client contact with the study physician was not limited to the HIV clinic. The physician coordinated care across institutional settings such as the county psychiatric hospital, jail, and drug

treatment facilities, as well as at the PBO office. The physician also conducted client outreach with the social worker, home visits for clients unable to make it to the clinic, and visits to clients who were admitted to the emergency room. This flexibility increased clients’ familiarity with the physician and provided the opportunity for clients to talk with him informally about health concerns. Seeing clients outside of the clinic allowed the physician to gather clinically relevant information about them that might not be reported in the small window of time allotted in a clinic appointment. For example, seeing a client in her or his single-room occupancy hotel room might yield information about asbestos, mold, or bed bugs that could be affecting the client’s health, but that might have otherwise gone unnoted in the clinic.

With clients unwilling or unable to come to the PBO office, the social worker built trust and rapport—tenets of the holding environment—through outreach. This was true in the case of Wilson (all names are pseudonyms), a 65-year-old street homeless man who injected drugs, had been left legally blind from a car accident in which he lost his left eye, and slept on a narrow median strip on a busy boulevard that was covered by an overpass. The social worker would drive past the median strip looking for him, and if he was there, she parked her car nearby and called his name from the overpass so that he could come meet her on the sidewalk. During the first months the social worker reached out to Wilson, he did not come into the office, but sometimes agreed to have a donut or cup of coffee somewhere near his encampment. After several outreach visits, Wilson confided that he was illiterate. Gradually, Wilson started coming to the office to have his mail read aloud to him and get assistance completing paperwork, which laid the foundation to help him secure senior citizen subsidized housing, begin methadone maintenance, and obtain a prosthetic eye.

During one of their final meetings, Wilson told the social worker, “Under the [overpass] I had time to think. I thought a lot. I thought about you and whether I could trust you and wanted to work with you. And you didn’t give up on me, never.” Wilson’s synthesis of the outreach period illustrates how he was able to internalize the holding environment created with the social worker (Ogden, 2004). Meeting Wilson “where he was at” helped

him create the psychological space to consider positive connections and potential change—space often collapsed by the inextricable consequences of complex physical and psychological trauma.

Because PBO largely took place in the community, the social worker had to navigate client confidentiality in semipublic spaces like restaurants and waiting rooms. Although she could not engage in discussions about confidential information in these spaces, she was able to follow up on these conversations in her car or other secure places. Clients, similarly, used various strategies to manage their confidentiality when in the community with the social worker. DeAndre, a 39-year-old man who recently had been released from prison, told the social worker while they were at the county hospital, “If anyone sees us, I’ll tell them you’re my attorney.” For DeAndre, being legally involved was more socially acceptable and normative than having a medical social worker.

A Holistic Approach to Community Stabilization: Addressing an Array of Needs. Although the primary focus of the PBO intervention was to connect clients to HIV care, it became apparent that assisting people with other components of community stabilization would be beneficial to engagement in such care. Housing was chief among these components. The social worker attempted to connect clients to federally subsidized supportive housing programs for homeless and HIV-positive adults. Although the average wait for a subsidized housing unit for homeless adults in the study’s locale was over a year, a total of eight clients obtained stable housing during the intervention. However, other clients were barred because of past eviction records and criminal convictions, both commonplace in this population (Desmond, 2012), and clients who were registered as sex offenders were permanently excluded from public or subsidized housing, denying them any affordable housing options.

In addition to housing, a key activity of the social worker was helping clients obtain SSI. This helped stabilize clients by providing them with financial resources (ranging from \$850 to \$973 per month) to meet basic needs. Because SSI is a permanent financial benefit (unlike general assistance or food stamps), people granted SSI have the assurance of a steady income, allowing them to focus on other needs, such as medical care. Although all PBO clients qualified as disabled, few were connected to SSI benefits because of the complexity of

the application process, overlaid with the instability of their lives. The social worker collaborated with a local nonprofit law center that had funding to represent HIV-positive adults through their SSI applications, appeals, and hearings free of charge. The social worker facilitated the process of obtaining needed benefits by acting as a point of contact with attorneys for hard-to-reach clients, locating clients when time-sensitive paperwork needed to be completed, and providing corroborating information regarding clients’ disabilities. Because the SSI analysts wanted to see that clients’ disabilities persisted even when they were adherent to standard HIV treatment, the social worker used the SSI process as a motivation for engagement in HIV care. Through these efforts eight clients obtained SSI benefits and one obtained indigenous tribal membership (which entitled her to annual dividends).

All clients also were connected to other health services, including dental care, optometry, podiatry, dermatology, and gynecology. Five clients obtained prescription eye glasses and one obtained a prosthetic eye. A total of 10 clients received dental care, including four who got dentures, which often involved up to a dozen appointments over a three-month period. Many adults with criminal justice involvement have poor oral health (Kulkarni, Baldwin, Lightstone, Gelberg, & Diamant, 2010) and only receive dental care when incarcerated. Often, this care is limited to extractions. A number of PBO clients indicated that dental care was their number one service priority, as having no teeth further stigmatized them in society, affected their self-esteem, and limited their nutritional food intake. Dental care was a motivating factor for some clients to see their HIV provider, because community dentists required medical documentation that clients were well enough to have dental work completed.

Using a nonjudgmental, nonadversarial, and non-confrontational approach (Arkowitz, Miller, & Rollnick, 2015), the social worker also helped eight clients access drug treatment programs, including three who enrolled in methadone maintenance. In addition, one client enrolled in a residential drug treatment program as a condition of her parole.

Navigating Criminal Justice Involvement. Clients’ levels of criminal justice involvement varied, from restrictive “high-control parole” to low-level court probation. Most clients lived with a pervasive distrust of the criminal justice system and feared

being reincarcerated. Clients longed to be disentangled from the constraints of community correctional control but were often too anxious or afraid to engage with a punitive system. For clients on parole or probation, this avoidance often led to their rearrest for “absconding.”

Twelve of the PBO clients asked the PBO social worker to accompany them to meetings with their parole or probation officers, attend court hearings, and provide documentation that they were engaged with case management services in an attempt to mitigate their legal involvement. In a service-poor landscape, many of the parole and probation officers expressed their support for PBO services. During the course of PBO, three clients were discharged from parole, which subsequently opened up housing opportunities for them and decreased their chances of being rearrested.

Given the high rates of recidivism, coordination with the county jail was also a key component of PBO. When clients became reincarcerated, the social worker was notified either by a direct collect call or through the jail HIV case manager, with a signed release by the client. The social worker visited clients in jail to work on discharge planning, including shelter, transportation, HIV care, and income. When able, she picked up clients from the county jail, located 26 miles from the downtown area where most of them stayed. The coordination of jail outreach was largely possible due to a master’s level discharge coordinator at the county jail who had a background in community mental health, was knowledgeable about issues of complex trauma, and was invested in forging relationships with community service providers. The jail discharge coordinator removed barriers frequently encountered by community providers by assisting the PBO social worker in obtaining clearance as a professional visitor and helping approve her jail visits, often on short notice.

Creating Therapeutic Value in the Mundane: Eating and Waiting. Nearly every PBO client experienced food insecurity, which is strongly correlated with medication nonadherence (Young, Wheeler, McCoy, & Weiser, 2014). In addition to providing snacks at the PBO office and connecting clients to the food bank, the social worker regularly took clients for meals before going to the HIV clinic or other appointments. Eating with clients served multiple purposes. It built rapport between

the social worker and the client; incentivized engagement in PBO; met a basic need (momentarily) so that the client could concentrate on medical, mental health, and other services; and promoted medication adherence (Koester et al., 2014).

Sharing meals also helped level the clinician–client power dynamic and opened up further therapeutic space to build trust and rapport. For example, the social worker took Carl, a 45-year-old client, for a “last meal” at McDonald’s before he voluntarily turned himself into jail custody precipitated by an outstanding warrant. After this meal, as Carl and the social worker drove to the county jail, he opened up about his family, his history of incarceration, how he felt about turning himself in, and strategies he used to get his basic needs met (for example, using the emergency room as a place to access food and shelter) when life on the streets became unbearable. This was the most Carl had ever spoken about himself, and this conversation may not have occurred had the meal not first provided the opportunity to sit and chat in a community space where Carl felt comfortable.

The social worker and clients established small rituals over meals—a client’s favorite type of food or the order in which the meal was eaten created meaningful experiences in the clinician–client dyad. For example, Stone, a 54-year-old man, kept a large bowl and spoon at the PBO office, which he used to make jailhouse mash—a mixture of ramen noodles, Cheetos, and tuna that he favored when he was incarcerated. Motivated by the availability of boiled water, Stone came to the office where he delicately and ceremoniously mixed the ingredients for his meal. It was over jailhouse noodles that Stone and the social worker applied for supportive housing and a free government mobile phone, and scheduled medical appointments.

A similar bonding process occurred through the communal act of waiting. It is common for clients to spend many hours at a single social services agency to obtain a benefit such as food stamps or general assistance. The social worker waited with clients as they navigated these systems. At the clinic, for example, she waited with clients for their appointments, accompanied them to the lab for blood draws, and helped them refill their medications at the pharmacy. She used this time to build rapport and gather clinical information from clients to inform their treatment. By waiting with the client, the social worker shared the burden of the frustration, boredom, and

impatience of waiting (Comfort, 2003). This shifted the interaction from a vertical process in which the client was “temporarily neglected” or “unattended to” by the agency to a horizontal relational process between social worker and client that made use of the wait time (Auyero, 2012). The social worker and client also took turns waiting if one person stepped outside for air, took a phone call, used the restroom, or got a snack. This team-based approach not only strengthened the therapeutic relationship, it helped humanize bureaucratic state agencies and counteracted the structural vulnerabilities that made clients susceptible to disengagement if they fell asleep, went out for a cigarette, or simply gave up on the waiting process.

As previously mentioned, sharing therapeutic interactions in multiple community spaces created opportunities for clients to discuss information they did not disclose in the formal office setting. Although the social worker completed biopsychosocial intakes of clients at PBO enrollment to gather information pertaining to their psychiatric, medical, and trauma histories, these assessments often yielded little information, as clients were understandably guarded. This was in stark contrast to the times the social worker and client waited together, during which a wealth of clinically relevant information emerged. It was common for clients to run into family members, people they grew up with, or people they “did time with” while navigating social services agencies. These interactions organically triggered memories for clients that yielded stories about the person’s family, incarceration history, and neighborhoods they grew up in—information clients might not have felt comfortable sharing, did not recall, or did not think was relevant during the intake process but that bore therapeutic and clinical significance.

This was the case for Stone, who had not reported any trauma history during his biopsychosocial assessment. A few weeks after enrolling in PBO, while waiting with the social worker for a prescription to be filled at the county hospital, he stated, “This is where I was taken when I was shot.” When Stone’s privacy could be ensured, the social worker followed up with him about the incident. Not only did Stone recount the time he was shot, he told the social worker of a separate assault with a lead pipe that left him in a coma and resulted in a traumatic brain injury. This conversation laid the foundation for Stone’s future SSI claim, which was granted with the help of the local free legal clinic.

DISCUSSION

The strategies for engagement used in PBO enabled the social worker to deliver intensive case management to a high-needs population of triply diagnosed adults and assist them in making progress toward community stabilization and improved health. For many clients, PBO was the first time that they had engaged with a service provider long enough to achieve a concrete result such as SSI approval or supportive housing. A strength of the PBO model was having a clinically trained social worker who was professionally equipped to conduct case management in community settings and to navigate a web of social services and health institutions alongside her clients. By being present with clients across multiple dimensions of their lives, the social worker was able to identify factors in one setting that were salient to—but often invisible in—another. She could then help clients decide when it was in their best interest to provide this supplemental information to obtain services tailored to their needs. Through the rapport the social worker developed with clients and her direct contact with the realities of their daily lives, she was well positioned to understand when a specific detail that someone might forget or be disinclined to mention to a medical provider (for example, lack of access to a secure storage area for medications) was clinically relevant for that client’s care.

Collaborating closely with the HIV physician allowed the social worker to help clients access other life-stabilizing resources such as housing and SSI. Because the social worker had an intimate knowledge of the clients’ medical and psychiatric history, she was able to help clients shape their claims for other resources that required documentation of mental health and medical diagnoses. Although most PBO clients were eligible for income and housing benefits, they were commonly not receiving these benefits because of complex and burdensome application processes. The social worker was able to explain how to access these services to the clients in lay terms and help them navigate systems that could be overwhelming and intimidating.

It is important to note that PBO also devoted resources to supporting the social worker. Social workers are affected by the setting in which they practice, especially when working with high-needs populations in fast-paced and stressful environments. Agency restrictions common to community mental health settings such as billing requirements,

time limitations, budget restrictions, and paperwork can contribute to provider burnout, employee turnover, and subsequent fragmented client care (Altman, 2009). PBO, in contrast, was able to establish an effective therapeutic holding environment for clients in part because the social worker herself was “held” in the agency’s framework. A competitive salary, weekly clinical supervision, and opportunities for professional development provided a safe and supportive working environment. In the face of instability, chaos, uncertainty, and violence experienced by clients, clinical supervision helped the social worker hold clients in her mind, process vicarious trauma, and examine rescue fantasies common to working with at-risk populations (Dunn, 2012). Meanwhile, by maintaining clear and consistent client boundaries (for example, regular work hours and a well-defined scope of work), the social worker built trust and modeled a healthy and stable relationship in which clients learned what to expect from a professional case manager.

For many clients, the experience of a relationship with the social worker that was safe, predictable, attuned, and caring was a transformative one. In the words of Herman (1997), trauma “recovery can take place only in the context of relationships; it cannot occur in isolation” (p. 133). PBO supported triply diagnosed clients in a holistic manner, providing them with an opportunity to connect to HIV care and improve their health on their own time frame and comfort level—conditions guided by the needs of the clients, not the needs of an agency. **HSW**

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PI: Kral; R01DA033847, PI: Comfort; and R01MD007679, PI: Lorwick). The authors thank Caroline Ahlstrom, David Greenberg, Elizabeth Kita, and the Project Bridge Oakland clients for their insights and collaboration.

Original manuscript received November 2, 2015

Final revision received April 6, 2016

Editorial decision April 25, 2016

Accepted May 9, 2016

Advance Access Publication March 14, 2017

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